

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01646

Reg. Dist. No. 116

1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years, 16 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? 10 years, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... KentCity or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Pauline Branigan

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidowed6. (b) Name of husband or wife... C. T. Branigan

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 18878. AGE: Years Months Days If less than one day
57 8 24 hrs. min.9. Birthplace... Millington, Kent County, Maryland
(Town, county, and state)10. Usual occupation... Housework11. Industry or business... Own home12. Name... Henry Spear
13. Birthplace... Millington, Kent County, Maryland14. Maiden name... Mollie Hazel
15. Birthplace... Millington, Kent County, Maryland16. Informant... Hospital RecordsAddress... E.S.S.H., Cambridge, Maryland17. Burial Date thereof Feb 9 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Millington MdLocation... Edward Lelloum18. Funeral director... John Maw J. MdAddress... 216119. 45 (Date rec'd by registrar) 19 45 John Maw J. Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 6 19 45 at 10:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 39 to February 6 19 45and that I last saw him/her alive on February 6 19 45Immediate cause of death... Pulmonary atelectasis

DURATION

12 hrs.Due to... Abdominal ascites2 weeksDue to... Cirrhosis of the liverUnknownOther conditions... Healed tuberculosis of the hip jointUnknown

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.
Autopsy results... Pulmonary atelectasis, cirrhosis of liver and arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Grace M. Branscombe, M. D. M. D. or otherAddress... E.S.S.H., Cambridge, Md. Date signed 2/6/45

UNITED STATES DEPARTMENT OF HEALTH

INSTITUTE OF STATISTICS

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FEB 17 1945
BUREAU V.S.

UNITED STATES DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1270

01647

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambury, Pa
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4.5 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambury, Pa
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Sarah Bryan

3.(b) Social Security Number

4. Sex

female

5. Color or race

colored

B.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Emerson Bryan6.(c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.) September 8 1898

8. AGE:

Years

Months

Days

If less than one day

4666

hrs.

min.

9. Birthplace

Christ Rock

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Samuel Young

13. Birthplace

Dorchester Co Md

MOTHER

14. Maiden name

Sarah Mason

15. Birthplace

Dorchester Co Md

16. Informant

Emerson Bryan

Address

Church Creek Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Feb 15 1945
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Church Creek cemetery

18. Funeral director

Lucas H. Bayne

Address

Cambury Md

19.

(Date rec'd by registrar)

Feb. 16 1945John Mason Jr. M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945, at 7:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 2 1945, to February 14 1945and that I last saw him alive on February 14 1945

Immediate cause of death

Cholera
Acute Cholangitis

DURATION

3 hrs
3 hrs

Due to

Mycobacterium

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carol M. H. Clark M.D.

M. D. or other

Address

200 N. Charles St.Date signed 2-15-45

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FEB 26 1945
BUREAU U.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

Reg. Dist. No. 116

01648

1. PLACE OF DEATH:

County DorchesterCity or town Camden
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Camden Md. Hospital

How long in hospital or institution?

4 weeks - 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Dor.City or town Bladesdale
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Wallace Bell

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

February 21, 1863

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

828

hrs.

min.

9. Birthplace _____

(Town, county, and state)

Virginia

10. Usual occupation _____

Farming

11. Industry or business _____

FATHER

12. Name _____

13. Birthplace _____

Virginia

MOTHER

14. Maiden name _____

15. Birthplace _____

Virginia Waller Bell

16. Informant _____

Address _____

Hospital Nurse
Brooklyn

17.

(Burial, cremation, or removal, which?)

Date thereof _____

(month) (day) (year)

Mar 3, 1945

Cemetery or crematory _____

Location _____

Cemetery
East New Market

19. Funeral director _____

Address _____

F. B. Willoughby
East New Market

19.

(Date rec'd by registrar)

2/28/45 John Macdonald
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945, at 8 ⁰⁵PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 29 1945, to FEB 28 1945and that I last saw him/her alive on 2/28 1945

Immediate cause of death _____

MYOCARDIAL FAILURE

DURATION

6 days

Due to _____

CANGRENE BOTHS FEET9 weeks

Due to _____

ARTERIOSCLEROSIS
GENERALIZED

?

Other conditions _____

SENILITY
Psychoses with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations _____

NO

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

Camden, Md

M. D. or other

Date signed 2/28/45

RECEIVED

MAR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

01649

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester
 County.....
 City or town.....Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Dorchester
 City or town.....Cambridge, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....239 Race St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME.....William J. Bishop

3. (b) Social Security Number.....none

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....Aug 30 - 1874

8. AGE: Years.....70 Months.....5 Days.....25 If less than one day..... hrs. min.

9. Birthplace.....Unknown
 (Town, county, and state)

10. Usual occupation.....Retired

11. Industry or business.....Fake work, etc.

12. Name.....Thomas Bishop

13. Birthplace.....Caroline Co.

14. Maiden name.....Unknown

15. Birthplace.....Caroline Co.

16. Informant.....Mrs. Mabel C. Sherman

Address.....Cambridge, Md.

17. Burial Date thereof.....Feb 27 - 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Greenwood

Location.....Cambridge, Md.

18. Funeral director.....Berneth R. Thomas

Address.....Cambridge, Md.

19. 3/26/45 John May Jr. M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb 25 1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19..... to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

Chronic Myocarditis

Due to.....

Due to.....

Other conditions.....Arterio-Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....John H. Shriver, Dep. Med. Exam.

M. D. or other.....Cambridge - Md. Date signed.....Feb 26/45

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MAR 6 1945
BUREAU U.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

01650

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

1. PLACE OF DEATH:

County *Prince George's*City or town *Camp Hill Md*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *10 Days*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Prince George's*City or town *Camp Hill Md*
(If outside city or town limits, write RURAL and give nearest town)Street No. *10 Days*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lawrence Cephas

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

*March 28, 1897*6. (c) If alive, give age *47* years

8. AGE:

Years

Months

Days

If less than one day

47 Years

hrs. min.

9. Birthplace

Duck Town, Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

None

FATHER

12. Name

Clumbus Cephas

13. Birthplace

Maryland

MOTHER

14. Maiden name

Emma Almon

15. Birthplace

Maryland

16. Informant

Mrs. Cephas

Address

Camp Hill Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 9, 1946
(month) (day) (year)

Cemetery or crematory

Wright City

Location

Near Camp Hill

18. Funeral director

H. H. Campbell

Address

201 Wash St Cambridge

19.

2-9-45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *FEBRUARY 7* 19*45* at *10:30 AM*

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

January 30 19*45* to *2/7* 19*45*and that I last saw him *alive* on *FEBRUARY 7* 19*45*

Immediate cause of death

Uremia
(Chronic nephritis)

DURATION

14 days

Due to

Hypertension
cardiorenal

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *No*

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. H. Campbell
H. H. Campbell M. D. or other
Address *201 Wash St Cambridge* Date signed *2/8/45*

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FEB 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

01651

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 20 High St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

J. W. Scott Cochran

3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Helen Beall
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Feb. 12 - 1850
 8. AGE: Years 95 Months 0 Days 15 If less than one day..... hrs. min.

9. Birthplace Cambridge, Md.
 (Town, county, and state)
 10. Usual occupation Lawyer & Teacher
 11. Industry or business.....
 12. Name David Cochran
 13. Birthplace Md.
 14. Maiden name Ann Calston
 15. Birthplace Md.

16. Informant Mrs. F. B. Powell
 Address Cambridge, Md.
 17. Burial Date thereof Mar 1 - 1945
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory Christ Church
 Location Cambridge, Md.
 18. Funeral director Reverend R. Thomas
 Address Cambridge, Md.

19. 2/28/45 John M. J. M.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945 at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 to.....
 and that I last saw him alive on 27 Feb. 1945

Immediate cause of death Double Strychnine

DURATION
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. no Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Gurstele M.D. M. D. or other
 Address Cambridge, Md. Date signed 2/28-1945

RECEIVED
MAR 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01652

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Thomas P.O. RFD #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Weeks
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Thomas P.O. RFD #3
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 3, Cambridge
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

Emma J. Cook

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife William H. Cook
6.(c) If alive, give age 56 years

7. Birth date of 10/24/1866.
(mo., day, yr.)

8. AGE: Years 78 Months 3 Days 23 If less than one day
hrs. min.

9. Birthplace Castle Haven, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name James Neal

13. Birthplace Maryland

14. Maiden name Jane Wilson

15. Birthplace Maryland

16. Informant Mrs. Fensa Cook

Address Cambridge, RFD # 3, Md.

17. Burial 2/20/1945.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Speddens Cemetery

Location Cambridge, RFD # 3, Maryland

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 2/19/45 John Macer J. M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from Dec. 30th 1944 to Feb. 17th 1945
and that it last saw her alive on Feb. 14th 1945

Immediate cause of death Profuse Vaginal Bleeding
DURATION 2 Mo.

Due to Carcinoma of uterus 8 mo.

Due to —

Other conditions marked Secondary anemia 8 mo.

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op. —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Eldridge H. Bedford

Address Cambridge Md Date signed 2-19-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 26 1968
BUREAU A.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

01653

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

1. PLACE OF DEATH:

County *Dorchester*
City or town *Cambridge*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Dorchester*City or town *Cambridge*
(If outside city or town limits, write RURAL and give nearest town)Street No. *203 Mill St.*
(If rural, give LOCATION)2.(a) If veteran, name war *None*

3. (a) FULL NAME

J. Simmons Dawson

3. (b) Social Security Number

214-05-0395

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 18* 19 *45* at *8:55 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 5 19 *45* to *Feb. 18* 19 *45*
and that I last saw him alive on *Feb. 17* 19 *45*

Immediate cause of death

DURATION

Coronary Artery Disease - Reversal

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please describe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (whore?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address *Cambridge, Md.* Date signed *2/29* 19456. (b) Name of husband or wife *Blanche LeCompte*8. (c) If alive, give age *57* years7. Birth date of deceased (mo., day, yr.) *October 22 1877*8. AGE: Years *67* Months *3* Days *26* If less than one day
hrs. min.9. Birthplace *Cambridge*
(Town, county, and state) *Salesman*

10. Usual occupation

11. Industry or business *Tombstone Dealer*12. Name *George H. Dawson*13. Birthplace *Talbot Co.*14. Maiden name *Anna Simmons*15. Birthplace *Dorchester Co.*16. Informant *Mrs. Blanche L. Dawson*Address *Cambridge, Md.*17. Burial Date thereof *Feb. 20, 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Christ Church Cemetery*Location *Cambridge, Md.*
Kenneth R. Thomas

18. Funeral director

Address *Cambridge, Md.*19. *Feb. 20 - 1945 John M. J. M. D.*
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 26 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Sh-C*

CERTIFICATE OF DEATH

Reg. Diat. No. *116*

1. PLACE OF DEATH:

County *Dorchester*City or town *Baltimore*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *10 days*Hospital, institution, or street address where death occurred *Baltimore - Maryland Hospital Inc.*How long in hospital or institution? *10 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Dorchester*City or town *Thurlock*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Shiam J Dally

3. (b) Social Security Number

4. Sex *Male*5. Color or race *White*6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *October 4, 1869*8. AGE: Years *75* Months *4* Days *11* If less than one day _____ hrs. _____ min.9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation *Farmer*

11. Industry or business _____

12. Name *Heine Dally*13. Birthplace *Delaware*14. Maiden name *Legates*15. Birthplace *Delaware*16. Informant *Hospital Records*Address *Baltimore, Maryland*17. *Burial* Date thereof *Feb 18 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Cemetery*Location *East New Market*18. Funeral director *F.B. McLaughlin*Address *East New Market*19. *2/16/45* *John Mace Jr. M*
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 15* 19 *45* at *1:05 P.* M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb 6* 19 *45* to *Feb 15* 19 *45*and that I last saw him alive on *Feb 15* 19 *45*Immediate cause of death *Cerebrovascular insufficiency**stroke of blood*DURATION *6 hrs*

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. *2/16/45*Autopsy results *Biopsy - same*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *James Mace Jr. M.D.*Address *Baltimore, Md* Date signed *2/16/45*

RECEIVED
FEB 26 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1172

01655

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Cambridge--Dorchester Co.City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 Weeks

Hospital, institution, or street address where death occurred:

Cambridge Maryland HospitalHow long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County LoganCity or town Logan
(If outside city or town limits, write RURAL and give nearest town)Street No. 47 High St.
(If rural, give LOCATION)2.(a) If veteran, name war -

3.(a) FULL NAME

Bobbie Edward Drake

3.(b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1943.8. AGE: Years 1 Months 16 Days 16 If less than one day
..... hrs. min.9. Birthplace Charleston, West Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Quincy T. Drake13. Birthplace Big Creek, West Virginia14. Maiden name Estelle Ruth Pauley15. Birthplace Logan Co., West Virginia16. Informant Quincy DrakeAddress Vienna, Md.17. Burial Date thereof Feb. 18, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Drake Family CemeteryLocation Logan Co., West Virginia18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Md.19. Feb. 23, 1945 John Mann Jr. M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1945 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....
and that I last saw him alive on 19.....

Immediate cause of death.....

Cardiac FailureDue to Enteritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Shriver, Dep. Med. Exam.
M. D. or otherAddress Cambridge Date signed Feb. 23/45

RECEIVED
FEB 26 1966
BUREAU A.B.

Note:

The reason why this certificate is late is because Dr. Lida O. Meredith refused to sign after giving us a release and assurance that she would sign. We then had to appeal to the Deputy Medical Examiner, which was done before interment but which has taken considerable time.

W. H. Campbell Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01656

Reg. Dist. No. 116

1. PLACE OF DEATH:
County... Dorchester
City or town... Rural--Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?... 50 yrs.
Hospital, institution, or street address where death occurred:
Home--Town Point--Nr. Cambridge
How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Dorchester
City or town... Rural--Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No... Town Point--Nr. Cambridge
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME
Nannie McBride Harding

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Matthew Harding

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1876. 6.(c) If alive, give age... 75 years

8. AGE: Years 69 Months - Days 28 If less than one day
.....hrs.min.

9. Birthplace... Salem, Dorchester Co., Md.
(Town, county, and state)

10. Usual occupation... Domestic

11. Industry or business... Home

12. Name... Samuel McBride

13. Birthplace... Maryland

14. Maiden name... Mary Raleigh

15. Birthplace... Maryland.

16. Informant... Howard Harding

Address... RFD Cambridge, Md.

17. Burial Date thereof Feb. 11, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Greenlawn Cemetery

Location... Cambridge, Md.

18. Funeral director... LeCompte's Funeral Service

Address... Cambridge, Md.

19. 2/12/45 John May Jr. M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH... February 8, 1945 at 11:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 8 1945 and that I last saw him alive on Feb 8 1945

Immediate cause of death... Cerebral Hemorrhage DURATION 6 mos.

Due to... Hypertension

Due to... Arteriosclerosis

Other conditions... Diabetes

Right - City
(Include pregnancy within 3 months of death)

Major findings of operations... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... John May Jr. M.D.

Address... Cambridge, Md. Date signed... 2-10-45

MARGIN RESERVED FOR BINDING

VS A15-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Meekins

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FEB 17 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

01657

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 years
 Hospital, institution, or street address where death occurred:
Eastern Shore Sattate Hosp.
 How long in hospital or institution? 5 mos. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. High Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Minnie Hooper

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Elston L Hooper

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 9 1865

8. AGE: Years 79 Months 8 Days 2 If less than one day
hrs.min.

9. Birthplace Connecticut
 (Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Hospital Records
 Address Cambridge, Mar land

17. Burial Date thereof Feb 14 1945
 (By what, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery
 Location East new Market
F. B. Halloway

18. Funeral director F. B. Halloway
 Address East new Market

19. 2/13/ 45 John Mace Jr. M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

February 11 45 10.00p M

20. DATE OF DEATH..... 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 7 1944 to February 11 1945
 and that I last saw h er alive on February 11 1945

Immediate cause of death..... DURATION
General Arteriosclerosis unknown
& Cerebral ""

Due to.....

Due to.....

Other conditions Hemiplegia 2 yrs.
Chronic Myocarditis unknown
 (Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Grace M. Branscombe M. D. or other

Address Cambridge Md. Date signed Feb. 11

MASSACHUSETTS DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

RECEIVED

FEB 17 1945

BUREAU V.S.

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01658

Reg. Dist. No. 116

1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Mon Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leah Horsey

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife John Horsey7. Birth date of deceased (mo., day, yr.) March 27 1965 8.(c) If alive, give age 12 years8. AGE: Years 79 Months 9 Days 5 If less than one day hrs. min.9. Birthplace Yorktown Dorchester Co Md
(Town, county, and state)10. Usual occupation sewn Home work

11. Industry or business

12. Name John Holli13. Birthplace Dorchester Co Md14. Maiden name Leah Johnson15. Birthplace Dorchester Co Md16. Informant Helen RickettsAddress Heddenburg Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 2/15/45
(month) (day) (year)Cemetery or crematory Bethel CemeteryLocation Cambridge Md18. Funeral director Louis F. BaynesAddress Cambridge Md19. 2-15- 19 45 John Horsey Jr. Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 19 45 at 2:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 19 45 to February 12 19 45 and that I last saw him alive on Jan 12 19 45

Immediate cause of death

Polymorphic Arterio Sclerosis
Chronic Hypertension

Due to

Due to

Other conditions

Arterio Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Conroy M. Sten M. D. or otherAddress Cambridge Md Date signed 2-15-45



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FEB 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01659

Reg. Dist. No. 116

1. PLACE OF DEATH:

County.....Dorchester

City or town.....Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....29 yrs. 8 mos.

Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital

How long in hospital or institution?.....29 yrs 8 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Dorchester

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Lankford

3. (b) Social Security Number
none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife.....Cora Lord

7. Birth date of deceased (mo., day, yr.) 8.(c) If alive, give age.....years

August 1 1861

8. AGE: Years Months Days If less than one day
83 7 mos. 12hrs.min.9. Birthplace.....Dorchester Co. Maryland
(Town, county, and state)

10. Usual occupation.....Farmer Unknown

11. Industry or business.....Unknown

12. Name.....Joseph Lankford

13. Birthplace.....Dorchester Co. Maryland

14. Maiden name.....Leah Martin

15. Birthplace.....Dorchester Maryland

16. Informant.....Hospital Records
Address.....Cambridge, Maryland17. Burial Date thereof.....Feb 16 1946
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory.....Residence to be unknown

Location.....F.B. McLaughlin

18. Funeral director.....

Address.....East New Market

19. February 15-45 John Mawg m.d.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 13 1946 at 4:55p.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 1 1939 to February 13 1945

and that I last saw him alive on February 13 1945

Immediate cause of death.....Chronic Myocarditis & Myocardial Deg. 2 yrs.

Due to.....Senility

Due to.....

Other conditions.....Generalized Arteriosclerosis 5 yrs.
Manic Depressive Psychosis 31
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?

23. SIGNATURE.....Grace F. Branscombe M. D. or other

Address.....Cambridge Md. Date signed.....Feb. 13/46

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FEB 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

Reg. Dist. No. 116

01660

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Cambridge Maryland HospitalHow long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. High Cambridge Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Nannie Chew LeCompte

3.(b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1853.

8. AGE: Years Months Days If less than one day

9132hrs.min.9. Birthplace Cambridge, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation School Teacher (Retired)

11. Industry or business

12. Name Dr. William Byrne LeCompte13. Birthplace Maryland14. Maiden name Sarah Burgess Keene15. Birthplace Maryland.16. Informant V. Calvin TriceAddress Locust St., Cambridge, Md.17. Burial Feb. 27, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cambridge CemeteryLocation Cambridge, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. Feb. 27, 1945

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1945, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945, to 2/25, 1945and that I last saw him alive on 2/25, 1945Immediate cause of death Coronary thrombosis

DURATION

Due to Right hemiplegia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy Steele M.D.Address Cambridge Md. Date signed 2/26-1945

M. D. or other

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MAR 6 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01661

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Anne ArundelCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Cross St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clayton Lee

3. (b) Social Security Number

224-03-3760

4. Sex

male

5. Color or race

acc

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

29621

hrs.

min.

9. Birthplace

Wheeling W. Va
(Town, county, and state)

10. Usual occupation

Gen. Laborer

11. Industry or business

Factory

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Jennie Morsley

15. Birthplace

Wheeling W. Va

16. Informant

Ida Bowen

Address

Cambridge, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb 13 1945
(month) (day) (year)

Cemetery or crematory

Wough Cemetery

Location

Cambridge, Md

18. Funeral director

W. M. Williams

Address

Cambridge, Md.

19.

(Date rec'd by registrar)

19.

2/13/45 John Tracy, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 5 1945, to February 8 1945and that I last saw him alive on February 8 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

Hypertension1944

Due to

acute sarcomatous10 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. A. Clear
M. D. or other

Address

Proverb RdDate signed 2-12-45

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FEB 17 1945
BUREAU V.S.

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MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

01662

Reg. Dist. No. 16

1. PLACE OF DEATH: County.....Dorchester City or town.....Cambridge (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?.....1 day Hospital, institution, or street address where death occurred: Cambridge-Maryland Hospital How long in hospital or institution?.....died while admitting				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State.....Maryland County.....Dorchester City or town.....Hurlock (If outside city or town limits, write RURAL and give nearest town) Street No.....X (If rural, give LOCATION) 2.(a) If veteran, name war.....															
3. (a) FULL NAME Luther Henry Long				3. (b) Social Security Number															
<table><tr><td>4. Sex male</td><td>5. Color or race colored</td><td colspan="2">6.(a) Single, married, widowed, or divorced divorced</td></tr></table> 6.(b) Name of husband or wifeVictoria Brown 7. Birth date of deceased (mo., day, yr.)December 12, 1903 8. AGE: <table><tr><td>Years</td><td>Months</td><td>Days</td><td>If less than one day</td></tr><tr><td>41</td><td>2</td><td>4</td><td>X hrs. X min.</td></tr></table> 9. BirthplaceDorchester County, Md. (Town, county, and state) 10. Usual occupationLaborer 11. Industry or businessFarm and Mill				4. Sex male	5. Color or race colored	6.(a) Single, married, widowed, or divorced divorced		Years	Months	Days	If less than one day	41	2	4	X hrs. X min.	MEDICAL CERTIFICATION 20. DATE OF DEATHFebruary 16, 1945, at 12 noon 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from X.....19....., to X.....19..... and that I last saw h.....X.....alive on X.....19..... Immediate cause of deathCardiac Failure DURATION Due to.....Lobar Pneumonia.....4 days Due to.....X..... Other conditions.....X (Include pregnancy within 8 months of death) Major findings of operationsXDate of op. Autopsy resultsX PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
4. Sex male	5. Color or race colored	6.(a) Single, married, widowed, or divorced divorced																	
Years	Months	Days	If less than one day																
41	2	4	X hrs. X min.																
12. NameTilghman A. Long 13. BirthplaceMaryland 14. Maiden nameAnnie E. Jackson 15. BirthplaceMaryland 16. InformantTilghman A. Long Address.....East NewMarket Md. 17. BurialDate thereof.....Feb 19 1945 (Burial, cremation, or removal) (Which?) (month) (day) (year) Cemetery or crematory.....Cambridge Location.....East New Market Funeral director.....F. B. Wilboughby Address.....East New Market 19. 2/19/ 1945John M. Murphy, M.D. (Date rec'd by registrar) Registrar				23. SIGNATUREJ. H. Shivers, Dep. Med. Exam. M. D. or other Address.....Cambridge, Md. Date signed.....Feb. 16/45															

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FEB 26 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116 119

1. PLACE OF DEATH:

County.....Dorchester
City or town.....Toddsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....Life
Hospital, institution, or street address where death occurred:
Toddsville
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland..... County.....Dorchester
City or town.....Toddsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.....Toddsville
(If rural, give LOCATION)
2.(a) if veteran, name war.....

3.(a) FULL NAME

Everette Wilson Meredith

3.(b) Social Security Number

212-165-024

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
6.(b) Name of husband or wife..... <u>Hilda Todd Meredith</u>		
6.(c) If alive, give age..... <u>29</u> years		
7. Birth date of deceased (mo., day, yr.) <u>Oct. 17, 1906.</u>		
8. AGE: Years <u>38</u>	Months <u>4</u>	Days <u>3</u> hrs. min.

9. Birthplace.....Toddsville, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation.....Mail Delivery

11. Industry or business.....

12. Name.....Harvey T. Meredith

13. Birthplace.....Maryland

14. Maiden name.....Rosie Lawson Meredith

15. Birthplace.....Maryland

16. Informant.....Mrs. Hilda Meredith

Address.....Toddsville, Maryland.

17.....Burial..... Date thereof.....Feb. 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Zion M. E. Cemetery

Location.....Toddsville, Maryland.

18. Funeral director.....LeCompte's Funeral Service

Address.....Cambridge, Maryland.

19.....Feb 22 1945.....Wilson & Pritchett
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 20 1945 at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb. 11 1945 to Feb. 20 1945
and that I last saw him alive on Feb. 19 1945

Immediate cause of death.....Chronic Myocarditis..... DURATION
6 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Dr. H. Shivers, M.D.
M. D. or other

Address.....Cambridge, Md...... Date signed.....Feb 20/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9372

CERTIFICATE OF DEATH

01664

Reg. Dist. No. 116

1. PLACE OF DEATH:

County.....Dorchester

City or town.....Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....3 mos. 8 days

Hospital, institution, or street address where death occurred:

Eastern Shore State Hosp., Cambridge, Md.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland

County.....Dorchester

City or town.....Eldorado

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Perry E. Milligan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife.....Ida Coulbourn Milligan

6.(c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.)

Sept. 8, 1872

8. AGE:

Years

Months

Days

If less than one day

72

5

20

hrs.

min.

9. Birthplace.....Eldorado, Dorchester County

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

FATHER

12. Name.....Isaac Milligan

13. Birthplace.....Dorchester County, Md.

MOTHER

14. Maiden name.....Matilda Murphy

15. Birthplace.....Dorchester County, Md.

16. Informant.....Hospital Records

Address

E. S. S. H., Cambridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

March 4 1945

(month) (day) (year)

Cemetery or crematory.....

Hill Crest Cemetery

Location.....

Federalburg, Maryland

18. Funeral director.....

J. J. Fralutson and Son

Address.....

Federalburg, Maryland

19.

3/2/45

19

45

John Maw J. M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 28 1945 at 2:33 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-20-

1944

to 2-28-

1945

and that I last saw him alive on

2-28-

1945

Immediate cause of death.....Congestive Heart Failure

DURATION

2-1-45

Due to.....Arteriosclerotic & Cardio-Vascular Disease.

4 mos.

Due to.....Senility

Other conditions.....Psychosis with Cerebral arteriosclerosis

(Include pregnancy within 8 months of death)

4 mos

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Ralph J. Benowitz M.D.

M. D. or other

Address.....E. S. S. H., Cambridge, Md. Date signed.....2-28-45

PLEASE TO THE UNITED STATES DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

RECEIVED

MAR 6 1945

BUREAU V.S.

M

Tawes

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

01665

Reg. Dist. No. 116 119

1. PLACE OF DEATH:
County Dorchester
City or town Bishop Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Bishop Head (Home)
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Rural-Bishop Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bishop Head
(If rural, give LOCATION)
2.(a) If veteran, name war -

3.(a) FULL NAME Louise Bramble Morris
3.(b) Social Security Number -

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
8.(b) Name of husband or wife Edward J. Morris
(Deceased) 8.(c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) 1857
8. AGE: Years 88 Months - Days - If less than one day - hrs. - min.

9. Birthplace Bishops Head
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Home
12. Name Hudson Bramble
13. Birthplace Not Known
14. Maiden name Not Known
15. Birthplace -

16. Informant Mr. Troy Morris
Address 233 Race St., Cambridge, Md.
11. Burial Date thereof Feb. 9, 1945.
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Greenlawn Cemetery
Location Cambridge, Md.
18. Funeral director LeCompte's Funeral Service
Address Cambridge, Md.
19. 2/9/1945 19 Wilson & Patchett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945. at 7:30A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Feb 6 1945
and that I last saw her alive on Feb 5 1945
Immediate cause of death Intercerebral hemorrhage DURATION 6 mo.
Due to -
Due to -
Other conditions -
(Include pregnancy within 8 months of death)
Major findings of operations - Date of op. -
Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -
23. SIGNATURE P. H. Tawes M. D. or other -
Address Baltimore, Md. Date signed 2/9/45

RECEIVED
MAR 3, 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 188

01666

1. PLACE OF DEATH:

County Dorchester
 City or town Williamstown - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Near Zion
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Williamstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Zion
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3.(a) FULL NAME

Hilda O. Paul

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Albert K. Paul
 6.(c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) February 4, 1896
 8. AGE: Years 49 Months 0 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Hurlock, Maryland
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name John M. Windsor

13. Birthplace Dorchester County, Maryland

14. Maiden name Alice C. Harding

15. Birthplace Dorchester County, Maryland

16. Informant Albert K. Paul

Address Williamstown, Maryland, R.F.D.

17. Burial Date thereof February 14, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Cemetery

Location Near Hurlock, Maryland

18. Funeral director J. J. Frampton & Son

Address Federalburg, Maryland

19. February 14, 1945 Charles Hastings
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1945 at 2:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1945 to Feb. 12 1945 and that I last saw her alive on Feb. 11 1945

Immediate cause of death Chronic Rheumatism (Osteoarthritis) DURATION _____

Due to _____

Due to _____

Other conditions hypertension (chronic)

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury St. Francis Injured at work? -

23. SIGNATURE Charles Hastings M. D. or other _____

Address Hurlock, Md Date signed 2-13-45

UNITED STATES DEPARTMENT OF HEALTH

CENTRE FOR DISEASE CONTROL

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

01667

1. PLACE OF DEATH: Dorchester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Dorchester
 City or town.....Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Rt. 2
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME
William C. Binder

3. (b) Social Security Number

4. Sex Mal. **5. Color or race** Colored **6. (a) Single, married, widowed, or divorced** widow
6. (b) Name of husband or wife Birtha Malack
Oct 17th **6. (c) If alive, give age** Dead years
7. Birth date of Oct. 18, 1888
 deceased (mo., day, yr.)

8. AGE: Years 56 Months 4 Days 9 If less than one day
 hrs. min.

9. Birthplace Dorchester Co
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER **12. Name** John W. Binder

13. Birthplace Dorchester Co

MOTHER **14. Maiden name** Annie Plach

15. Birthplace Dorchester Co

16. Informant Annie Plach

Address Vienna, Md. RFD

17. Burial Mar 1, 1945
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory York Neck

Location Levitts Bayneum

18. Funeral director Cambridge, Ind.

Address 3/1/45

19. (Date rec'd by registrar) John M. J. M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Feb 26 1945 and that I last saw him alive on Feb 26 1945

Immediate cause of death Cerebral Hemorrhage 2 days

Due to

Due to

Other conditions

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RECEIVED
MAR 6 1949
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

01668

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambidge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Cambidge - Maryland HospitalHow long in hospital or institution? Five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town R. K. K. K. K.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Boy Sampson

3. (b) Social Security Number

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced new-born6. (b) Name of husband or wife None

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 18th, 19458. AGE: Years _____ Months _____ Days 4 1/2 It less than one day _____ hrs. _____ min.9. Birthplace Cambidge, Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

12. Name Low Jolly13. Birthplace Maryland14. Maiden name Catherine Sampson15. Birthplace Maryland16. Informant Mother

Address _____

17. Burial Date thereof 2/26/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location East New Market,Nelson Elbert18. Funeral director East New Market, Md.

Address _____

19. 2/26/45 John Maceph. M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 19 45 at 9:28 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18th 19 45 to February 23 19 45 and that I last saw him alive on February 22, 19 45

Immediate cause of death _____ DURATION _____

Congenital Heart Disease Since birth

Due to _____

Due to _____

Other conditions Prematurity

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. O. Mearlith M. D. or other _____Address Cambidge, Maryland Date signed Feb. 23, 1945

RECEIVED

MAR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01669

Reg. Dist. No. 110

1. PLACE OF DEATH:

County DorchesterCity or town East New Market - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Near Shiloh

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town East New Market - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Shiloh
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Lina Sampson

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Andrew Sampson

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1862

8. AGE: Years Months Days If less than one day

82 7 4 hrs. min.9. Birthplace Dorchester County, Maryland
(Town, county, and state)10. Usual occupation Housework11. Industry or business Home12. Name Caleb Whittington13. Birthplace Dorchester County, Maryland14. Maiden name Sophia Stanley15. Birthplace Dorchester County, Maryland16. Informant Edward SampsonAddress East New Market, Maryland, R.F.D.17. Burial Date thereof February 19 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Thompson's CemeteryLocation Near East New Market, Maryland18. Funeral director J. J. Traubert and SonAddress Federalburg, Maryland19. February 19 - 1945 - Charles Hastings
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 16 19 45, at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 14 19 45 to Feb. 16 19 45and that I last saw him alive on Feb. 14 19 45Immediate cause of death Chronic myocardial Degeneration 10 yrs +Due to General arteriosclerosis 10 yrs +Due to age

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Harrison MDAddress Hurlock MdDate signed 2/17/45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

01670

CERTIFICATE OF DEATH

Reg. Dist. No. 1.65

1. PLACE OF DEATH:

County DorchesterCity or town Fishing Creek
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Fishing Creek
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 1

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Lillie Tyler Simmons

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mr. H. SimmonsDeceased6. (c) If alive, give age 19 years7. Birth date of deceased (mo., day, yr.) 2-28-18798. AGE: Years 66 Months ✓ Days 1 If less than one day

hrs. min.

9. Birthplace Fishing Creek, Md.

(Town, county, and state)

10. Usual occupation Home11. Industry or business Home12. Name Matthew T. Tyler13. Birthplace Md.14. Maiden name Angeline Crighton15. Birthplace Md.16. Informant Major B. MeadeAddress Fishing Creek, Md.17. Burial ✓ Date thereof 3/2/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Travis MemorialLocation Fishing Creek, Md.18. Funeral director Re Capt. Ernest JonesAddress Cambridge, Md.19. March 19 45

(Date rec'd by registrar)

James W. Meade RegistrarLOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1945 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1, 1943 to Dec. 28, 1945and that I last saw her alive on Dec. 28, 1945Immediate cause of death Chronic NephritisDURATION 3 yrsDue to FollowingChronic NephritisDue to (1943)Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations XAutopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) XMeans of injury X Injured at work? X23. SIGNATURE James W. Meade M.D.Address Fishing Creek, Md.Date signed 3/1/45

RECEIVED
MAR 6 1945
BUREAU V.E.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01671

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambury R.F.D. 2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambury Route 2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mamie Stanley

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Cardell Stanley7. Birth date of deceased (mo., day, yr.) July 9 1895 6.(c) If alive, give age 32 years8. AGE: Years 49 Months 7 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace Cambury Md
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Sylvester Martin13. Birthplace Dorchester Md14. Maiden name Ellen Pender15. Birthplace Dorchester Md16. Informant Cardell StanleyAddress Cambury Route 217. (Burial, cremation, or removal, Which?) Burial Date thereof Feb 23 1945
(month) (day) (year)Cemetery or crematory AnyLocation Any Cem18. Funeral director Levin H. BayneAddress 221 Washington St Camb Md19. 2/24/45 19 45 John MacFarland
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1945 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 11 1944 to February 22 1945and that I last saw him alive on February 17 1945Immediate cause of death Pulmonary embolism

DURATION

15 mos

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 5 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Carroll M St Clair M.D. M. D. or otherAddress One State St Date signed 2-28-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 6 1945
BUREAU OF

UNITED STATES GOVERNMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ^{46P}

CERTIFICATE OF DEATH

01672

Reg. Dist. No. 112

1. PLACE OF DEATH:

County DorchesterCity or town Vienna
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: -How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Vienna
(If outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

John A. Styles

3. (b) Social Security Number

218-16-53944. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Florence Styles7. Birth date of deceased (mo., day, yr.) August 30, 1890 8.(c) If alive, give age - years8. AGE: Years 54 Months 5 Days 19 If less than one day - hrs. - min.8. Birthplace Dorchester County, Maryland
(Town, county, and state)10. Usual occupation Day Laborer11. Industry or business Farm12. Name John Henry Styles13. Birthplace Dorchester County, Maryland14. Maiden name No data available15. Birthplace -18. Informant Delama ConawayAddress Vienna, Maryland17. Burial Date thereof February 21 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Vienna Colored CemeteryLocation Vienna, Maryland ✓18. Funeral director J. J. Traubman & SonAddress Federalburg, Maryland19. Feb 21 19 45 Mrs Robert L. Wright
(Date rec'd by registrar) (year) (Signature) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 19 19 45, at 6 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15, 1944 to Feb 19, 1945and that I last saw him alive on Feb 2 19 45Immediate cause of death Leukemia of DURATION -LeukemiaDue to -Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured of work? -23. SIGNATURE L. E. Francis M. D. or other -Address Sheslock Date signed 2-19-45

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RECEIVED
MAR 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

01673
Reg. Diat. No. 118119

1. PLACE OF DEATH:

County... Dorchester
City or town... Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs.
Hospital, institution, or street address where death occurred:
Cambridge Maryland Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Dorchester
City or town... Rural--Bishops Head
(If outside city or town limits, write RURAL and give nearest town)
Street No... Bishops Head
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Mary Isabella Sullender

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife... John N. Sullender
(Deceased)

7. Birth date of... Jan. 20, 1865.
6. (c) If alive, give age... years

8. AGE: Years 80 Months - Days 10
If less than one day... hrs. ... min.

9. Birthplace... Bishops Head, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation... Domestic

11. Industry or business... Home

12. Name... Wm. H. Pritchett

13. Birthplace... Maryland

14. Maiden name... Mary J. Johnson

15. Birthplace... Maryland.

16. Informant... Mr. Johnson Robinson

Address... Cambridge, Md.

17. Burial Date thereof Feb. 12, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... St. Thomas Cemetery

Location... Bishops Head, Md.

18. Funeral director... LeCompte's Funeral Service
Address... Cambridge, Md.

19. Feb 12 1945 Wilson & Pritchett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 10, 1945 at... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 8 1945 Feb 10 1945
and that I last saw her alive on Feb 10 1945

Immediate cause of death... Stroke
Cardiovascular

DURATION

10 days

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O. H. Tamm M. D. or other

Address Baltimore, Md. Date signed 2/12/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

01674

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:
County Dorchester
City or town Rural - Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
Rte #2, Cambridge: c/o Dr. C. V. Taylor
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Race & Goldsborough Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish-American

3. (a) FULL NAME

Charles H. Taylor

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emma Blanche Taylor7. Birth date of deceased (mo., day, yr.) October 12, 1871 8. (c) If alive, give age 66 years

8. AGE: Years 73 Months 4 Days 13 If less than one day
.....hrs.min.

9. Birthplace nr. Cecilton, Cecil Co., Md.
(Town, county, and state)10. Usual occupation Travelling Salesman, retired11. Industry or business Wholesale Dry Goods & Notions12. Name John Wesley Taylor13. Birthplace Cecil Co., Md.14. Maiden name Susan St. Clair15. Birthplace Hagerstown, Md.16. Informant Charles V. Taylor Cambridge,Address Eastern Shore State Hospital Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1945
(month) (day) (year)

Cemetery or crematory Mt. Olivet
Baltimore, Md.
Location

18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Md.19. 2/26/45 19 45 John Mace Jr. M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 at 6:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb. 22 1945, to Feb. 25 1945
and that I last saw him alive on Feb. 25 1945

Immediate cause of death Chronic Myocarditis & Myocardial Degeneration DURATION 2 yrs.

Due to Arteriosclerosis 18 yrs.

Due to

Other conditions Acute cardiac dilatation 8 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles W. Taylor M.D. M. D. or otherAddress Rte. #2 Cambridge, Md. Date signed 2/25/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01675

CERTIFICATE OF DEATH

Reg. Diat. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 YearsHospital, institution, or street address where death occurred:
203 Peachblossom Ave.How long in hospital or institution? —

3. (a) FULL NAME

Elmer C. Todd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 203 Peachblossom Ave.
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (b) Social Security Number

220-10-6133

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Jan. 12, 1895.

8. AGE:

Years 50Months 1Days 10

If less than one day

hrs. — min. —9. Birthplace Toddville, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Waterman11. Industry or business Seafood12. Name Amos B. Todd13. Birthplace Maryland14. Maternal name Mary McNamara15. Birthplace Maryland.16. Informant Mr. Lee SinclairAddress Cambridge, Maryland.17. Burial Date thereof Feb. 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dorchester Memorial ParkLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Md.19. 2/23/45 John Mace Jr. md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945 at 12:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 3, 1945 to Feb. 20, 1945
and that I last saw him alive on Feb. 20, 1945Immediate cause of death Wrenia

DURATION

3 daysDue to Chronic hepatitis2 yrsDue to Myocarditis2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Bunker
32 Peachblossom Ave., Cambridge, Md.
M. D. or other 2-23-45
Date signed

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FEB 26 1963
BUREAU A.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01676

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:

County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Virginia Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Thomas J. Fregoe

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 15-1866

8. AGE: Years 78 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace Dor. Co.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Wm. H. Fregoe
13. Birthplace Dor. Co.

MOTHER 14. Maiden name Sarah C. Fickens
15. Birthplace Dor. Co.

16. Informant Mrs. George W. Taylor
Address Cambridge Md R 20

17. Burial (Burial, cremation, or removal. Which) Burial Date of burial 2/27/45
(month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge Md.

18. Funeral director Kenneth R. Thomas
Address Cambridge, Md.

19. 2/26/45 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Pneumonia - Accidental

Due to Burning of house

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Feb 25/45

Where did injury occur? Cambridge (City or town) Dor. (County) Md. (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Fire Injured at work? No

23. SIGNATURE J. H. Shivers, Dep. Med. Exam.
M. D. or other

Address Cambridge - Md. Date signed Feb 24/45

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 6 1945
BUREAU

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 01677 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 737 Cedar St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cecelia Salem Vaughn

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Wm. Saul Vaughn6.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) August 15 19028. AGE: Years 42 Months 4 Days 16 If less than one day hrs. min.9. Birthplace Madison Md
(Town, county, and state)10. Usual occupation Seamstress

11. Industry or business

12. Name Charles Kane13. Birthplace Madison Md14. Maiden name Sarah Clash15. Birthplace Madison Md16. Informant Saul VaughnAddress 737 Cedar St Cambridge Md17. Burial Date thereof Feb 13 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Old Field Mt18. Funeral director John Moore Jr. MdAddress Cambridge Md19. 2/13/45 19 45 John Moore Jr. Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945 at 12:30 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1945 to February 11 1945and that I last saw him alive on February 11 1945Immediate cause of death Cerebral HemorrhagesubarachnoidDue to Brain HypertensionDue to Brain HypertensionOther conditions Cerebral Paralysis

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. 1945Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?23. SIGNATURE Carroll M St Clair MdAddress Cambridge Md Date signed 2-12-45

RECEIVED

FEB 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11678 116

1. PLACE OF DEATH:

County CarrollCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Edgewood Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Sherley Woolgar

3. (b) Social Security Number

4. Sex female 5. Color or race caucasian 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Joseph Woolgar6. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) March 28 18928. AGE: Years 52 Months 10 Days 21 If less than one day hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation sen. housework

11. Industry or business

12. Name Harrison Huntley13. Birthplace King & Queen Co Va14. Maiden name Unknown15. Birthplace Unknown16. Informant Joseph WoolgarAddress Edgewood Ave Cambridge Md17. Buried Date thereof Feb 21 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bethel CemeteryLocation Cambridge Md18. Funeral director Sam H. BaynesAddress Cambridge Md19. Feb. 21 - 19 45 John Macfarlane MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 45 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 12 19 45 to February 19 19 45and that I last saw him alive on February 19 19 45Immediate cause of death Pulmonary EdemaAcute Myocardial InfarctionDue to Ch. MyocardialCh. HypertensionDue to Ch. HypertensionOther conditions Sen. HypertensionNausea, Headache, etc.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carol M. Steele MD

M. D. or other

Address Quincy St Date signed 2-19-45

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FEB 26 1965
BUREAU V.B.

ORIGINAL NOT TO BE REPRODUCED